San Bernardino County In-Home Supportive Services Public Authority
Provider Registry Application
(Please print clearly)

Name: _____ Date: _____

Address: _____ CA, _____
(Street) (City) (Zip Code)

Mailing Address: _____ CA,_____
☐ Same

Phone #: (_____) _____ Other Phone: (_____) _____

E-Mail _____

1. Are you a United States Citizen over the age of 18? ☐ YES ☐ NO
If **NOT**, are you a Legal Alien authorized to work in the United States? ☐ YES ☐ NO

2. Have you ever been convicted of a felony or misdemeanor? ☐ YES ☐ NO
If **YES**, list date(s) and conviction(s): _____
(exclude minor traffic violations)

All Applicants will be required to undergo a Criminal Background Check

3. Have you used any illegal drugs in the past year? ☐ YES ☐ NO

4. Language (s)

☐ English	☐ Speak	☐ Read	☐ Write
☐ Spanish	☐ Speak	☐ Read	☐ Write
☐ Other_____	☐ Speak	☐ Read	☐ Write

5. Please let us know what skills you feel comfortable performing in a client's home *(Please √ check all boxes that apply, these are based on approved tasks by IHSS)*

(If offering transportation services, you will need to provide proof of valid Auto Insurance Coverage)

Domestic Services
- ☐ Light housekeeping

Related Services
- ☐ Prepare meals
- ☐ Meal clean up
- ☐ Routine laundry
- ☐ Shopping for food
- ☐ Other shopping errands

Accompaniment Services
- ☐ Medical appointments
- ☐ Alternative resources

- ☐ **Protective Supervision** *(providing care to assure safety of client)*
- ☐ **Teaching / Demonstration** *(teaching self-care skills)*
- ☐ **Paramedical Service** *(services approved by a Doctor)*

Yard Hazard
- ☐ Remove grass or weeds, Trash
- ☐ Remove ice / snow

Non-Medical Personal Services
- ☐ Respiration assistance (breathing assistance)
- ☐ Bowel, bladder care (diapers, bedpans, enemas, colostomy bags, catheters)
- ☐ Feeding
- ☐ Routine bed baths
- ☐ Dressing
- ☐ Ambulation (assistance with walking)
- ☐ Moving in and out of bed
- ☐ Bathe, oral hygiene/grooming
- ☐ Rub skin, repositioning, help on/ off seats, in/out of vehicle
- ☐ Care / assistance with prosthesis (includes assistance with medication, artificial limbs / braces)

6. Days and hours desired: Please Check the days and times you are available:

Mornings	☐ Mon	☐ Tue	☐ Wed	☐ Thur	☐ Fri	☐ Sat	☐ Sun
Afternoons	☐ Mon	☐ Tue	☐ Wed	☐ Thur	☐ Fri	☐ Sat	☐ Sun
Evenings	☐ Mon	☐ Tue	☐ Wed	☐ Thur	☐ Fri	☐ Sat	☐ Sun
Overnight	☐ Mon	☐ Tue	☐ Wed	☐ Thur	☐ Fri	☐ Sat	☐ Sun

7. Desired hours per week: How many hours are you available to work per week? _____

8. Are you willing to work "On Call,"? ☐ YES ☐ NO
(Available to work with in an hour of being called by a Public Authority representative)

9. Are you willing to work "Respite care."? ☐ YES ☐ NO
(Available to fill in for a provider who has requested time off on a temporary basis)

10. AUTOMOBILE INSURANCE INFORMATION
(PLEASE PROVIDE A COPY OF A VALID DRIVER'S LICENSE AND PROOF OF INSURANCE)

Do you drive? ☐ YES ☐ NO	Do you have access to a car? ☐ YES ☐ NO Other transportation?	
Driver License Number	**State**	**Expiration Date**
Name Of Insurance Company	**Agent's Name**	**Telephone**
Has your license ever been suspended or revoked? ☐ YES ☐ NO If yes please explain:_____		

11. Geographic preference (Please √ check the boxes for the areas you are most interested in working. If a city is not listed, write that city on the line that says "other")

West End	**Valley**	**Lower Desert**	**Upper Desert**	**Mountains**
☐ Chino	☐ San Bernardino/Highland	☐ 29 Palms/Joshua Tree	☐ Adelanto	☐ Crestline
☐ Montclair	☐ Colton	☐ Needles	☐ Amboy / Kelso	☐ Big Bear
☐ Upland	☐ Fontana	☐ Trona	☐ Apple Valley	☐ Lake Arrowhead
☐ Ontario	☐ Rialto	☐ Big River	☐ Barstow	☐ Ivanpah
☐ Rancho	☐ Redlands/Crafton	☐ Red Mountain	☐ Fort Irwin	☐ Running Springs
	☐ Yucaipa	☐ Yucca Valley	☐ Hesperia	
			☐ Lucerne Valley	
			☐ Phelan	
			☐ Victorville	

Other: _____

12. CURRENT OR MOST RECENT EMPLOYER: *(Please complete all boxes)*

Client/ Employer: Job Title :	From: Month / Year To: Month / Year	Phone : ( ) -	Office Use Only ☐ VERIFIED INITIALS:
Address: STREET	CITY	STATE	ZIP
Duties:	Reason for Leaving:		
	May we contact? ☐ YES ☐ NO		

☐ NEVER EMPLOYED

13. VOLUNTEER EXPERIENCE

Name Of Company	How Long? _____ Months _____ Years	Duties?
Name Of Company	How Long? _____ Months _____ Years	Duties?

14. OTHER REFERENCES: Please list 2 references who do not reside in the same household and who are not related to you **OR** you may submit 2 letters of reference.

NAME: PHONE: ( ) - ADDRESS: STREET CITY STATE ZIP		**OFFICE USE ONLY**
HOW LONG HAVE YOU KNOWN THIS PERSON?		☐ VERIFIED
WHAT IS YOUR RELATIONSHIP TO THIS PERSON? (FRIEND, PASTOR, CO-WORKER, NEIGHBOR..)		INITIALS:
	OFFICE USE ONLY ☐ LETTERS RECEIVED INITIALS _____	

NAME: PHONE: ( ) - ADDRESS: STREET CITY STATE ZIP		**OFFICE USE ONLY**
HOW LONG HAVE YOU KNOWN THIS PERSON?		☐ VERIFIED
WHAT IS YOUR RELATIONSHIP TO THIS PERSON? (FRIEND, PASTOR, CO-WORKER, NEIGHBOR..)		INITIALS:
	OFFICE USE ONLY ☐ LETTERS RECEIVED INITIALS _____	

15. TRAINING & CERTIFICATES: Do you have any other skills that you feel would be a benefit to the IHSS client? *(Please bring copies of certificates & current cards to your interview.)*

☐ CNA ☐ CHHA ☐ CPR ☐ First Aid ☐ Medical Assistant ☐ Hospice

☐ Other _____ ☐ **NONE**

16. You will be scheduled for an application review with other registry applicants. Please answer the following questions prior to your meeting.

Provider Preferences

Do you smoke? (Clients may request a non-smoker)	☐ YES	☐ NO
Will you work for a smoker?	☐ YES	☐ NO
Do you have a client preference?	☐ MALE ☐ FEMALE	☐ EITHER
Will you work in a home with a family pet?	☐ YES	☐ NO
Are you allergic to:	☐ CAT ☐ OTHER	☐ DOG
Will you work for more than one client?	☐ YES	☐ NO
Will you take a live in position?	☐ YES	☐ NO
How many total years of care-giving experience do you have?	_____YR	_____MO

The IHSS Client as the employer

The Public Authority Registry is here to assist **IHSS clients** in selecting potential providers. We supply clients with names of pre-screened providers who are available to work. Do you understand that the Registry does not have or make job offers for the clients?	☐ YES	☐ NO
Do you understand that the IHSS client is the employer and makes the decision to hire or to terminate a provider's employment as they desire for any reason?	☐ YES	☐ NO
Do you understand that an IHSS client may request that not smoke, wear perfumes or may make reasonable requests in regards to your personal appearance / hygiene?	☐ YES	☐ NO

17. How did you learn about the Public Authority's Registry?

☐ IHSS Orientation ☐ Current Provider ☐ Friend ☐ Mailer ☐ Radio

☐ Job Fair ☐ Newspaper ☐ Television ☐ Other (Please specify) _____

Please list any questions you have for the Public Authority : _____

_____

_____

CERTIFICATION:

I certify that all statements made on this application are true and complete to the best of my knowledge. I understand that any false statements or misrepresentations may result in my disqualification for Registry Services. I understand that the references that I have provided will be checked.

SIGNATURE: _____ **DATE:** _____

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